# APPENDIX C

## SAMPLE CLINICAL RECORDS INCORPORATING OASIS-B1 (12/2002) DATA SET

Appendix C contains six sample assessment forms and a patient tracking sheet which incorporate the OASIS-B1 (12/2002) data items into the home health agency clinical record. They are not official CMS forms. Each home health agency is expected to integrate OASIS items into its comprehensive assessment form, but no specific comprehensive assessment form has been mandated or sanctioned. These forms are provided as examples of OASIS integration into clinical documentation. **Note that those items that will become effective 10/1/2003 are not included on these forms. New sample forms will be available in fall 2003 that replace current wording with the 10/1/2003 items.**

# PATIENT TRACKING SHEET



1. **(M0010) Agency Medicare Provider Number:**
__ __ __ __ __ __

2. **(M0012) Agency Medicaid Provider Number:**
__ __ __ __ __ __ __ __ __ __ __ __ __ __ __

**Branch Identification**

3. **(M0014) Branch State:** __ __

4. **(M0016) Branch ID Number:** __ __ __ __ __ __ __ __ __ __

5. **(M0020) Patient ID Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

6. **(M0030) Start of Care Date:**
__ __ – __ __ – __ __ __ __
m m d d y y y y

7. **(M0032) Resumption of Care Date:**
__ __ – __ __ – __ __ __ __
m m d d y y y y
☐ NA - Not Applicable

8. **(M0040) Patient Name:**
(First) (MI) (Last) (Suffix)

9. **Patient Address:**
Street, Route, Apt. Number - not P.O. Box
City **(M0050)** State **(M0060)** Zip Code

10. **Patient Phone:**
(__ __ __) __ __ __ - __ __ __ __

11. **(M0063) Medicare Number:**
__ __ __ __ __ __ __ __ __ __ __ __
(including suffix if any)
☐ NA - No Medicare

12. **(M0064) Social Security Number:**
__ __ __ __ __ __ __ __ __
☐ UK - Unknown or Not Available

13. **(M0065) Medicaid Number:**
__ __ __ __ __ __ __ __ __ __ __ __ __
☐ NA - No Medicaid

14. **(M0066) Birth Date:**
__ __ – __ __ – __ __ __ __
m m d d y y y y

15. **(M0069) Gender:** ☐ 1 - Male ☐ 2 - Female

16. **(M0072) Primary Referring Physician ID:** __ __ __ __ __ __ __ __ __ __ (UPIN#) ☐ UK - Unknown or Not Available

Name_____ Phone (__ __ __) __ __ __ - __ __ __ __

Address_____ FAX (__ __ __) __ __ __ - __ __ __ __

17. **Marital Status:** ☐ Not Married ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Unknown

18. **(M0140) Race/Ethnicity** (as identified by patient): **(Mark all that apply.)**
☐ 1 - American Indian or Alaska Native ☐ 2 - Asian ☐ 3 - Black or African-American ☐ 4 - Hispanic or Latino ☐ 5 - Native Hawaiian or Pacific Islander ☐ 6 - White ☐ UK - Unknown

19. **Emergency Contact (Name and Relationship):**

20. **Emergency Contact Address:**

21. **Emergency Contact Telephone No.:**
(__ __ __) __ __ __ - __ __ __ __

22. **(M0150) Current Payment Sources for Home Care:**
**(Mark all that apply.)**
☐ 0 - None; no charge for current services
☐ 1 - Medicare (traditional fee-for-service)
☐ 2 - Medicare (HMO/managed care)
☐ 3 - Medicaid (traditional fee-for-service)
☐ 4 - Medicaid (HMO/managed care)
☐ 5 - Workers' compensation
☐ 6 - Title programs (e.g., Title III, V or XX)
☐ 7 - Other government (e.g., CHAMPUS, VA, etc.)
☐ 8 - Private insurance
☐ 9 - Private HMO/managed care
☐ 10 - Self-pay
☐ 11 - Other (specify) _____
☐ UK - Unknown

# START OF CARE ASSESSMENT
## (Also used for Resumption of Care Following Inpatient Stay)



Client's Name:

Client Record No.



## A. DEMOGRAPHIC INFORMATION - Update Patient Tracking Sheet at ROC

1. **(M0080) Discipline of Person Completing Assessment:**
   - ☐ 1 - RN
   - ☐ 2 - PT
   - ☐ 3 - SLP/ST
   - ☐ 4 - OT

2. **(M0090) Date Assessment Completed:**

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

3. **(M0100) This Assessment is Currently Being Completed for the Following Reason:**

**Start/Resumption of Care**

- ☐ **1 - Start of care—further visits planned**
- ☐ **3 - Resumption of care (after inpatient stay)**

Follow-Up

- 4 - Recertification (follow-up) reassessment
- 5 - Other follow-up

Transfer to an Inpatient Facility

- 6 - Transferred to an inpatient facility—patient not discharged from agency
- 7 - Transferred to an inpatient facility—patient discharged from agency

Discharge from Agency — Not to an Inpatient Facility

- 8 - Death at home
- 9 - Discharge from agency

4. **Economic/Financial Problems or Needs** (describe):

5. **(M0175)** From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**
   - ☐ 1 - Hospital
   - ☐ 2 - Rehabilitation facility
   - ☐ 3 - Skilled nursing facility
   - ☐ 4 - Other nursing home
   - ☐ 5 - Other (specify) _____
   - ☐ NA - Patient was not discharged from an inpatient facility **[ If NA, go to *#8 - Medical or Treatment Regimen Change* ]**

6. **(M0180) Inpatient Discharge Date** (most recent):

   __ __ – __ __ – __ __ __ __
   m m d d y y y y

   ☐ UK - Unknown

7. **(M0190) Inpatient Diagnoses** and ICD-9-CM code categories (three digits required; five digits optional) for only those conditions treated during an inpatient facility stay within the last 14 days (no surgical or V-codes):

| Inpatient Facility Diagnosis | ICD-9-CM |
|---|---|
| a. _____ | (__ __ __ . __ __) |
| b. _____ | (__ __ __ . __ __) |

8. **(M0200) Medical or Treatment Regimen Change Within Past 14 Days:** Has this patient experienced a change in medical or treatment regimen (e.g., medication, treatment, or service change due to new or additional diagnosis, etc.) within the last 14 days?
   - ☐ 0 - No **[ If No, go to *#10 - Conditions Prior* ]**
   - ☐ 1 - Yes

9. **(M0210)** List the patient's **Medical Diagnoses** and ICD-9-CM code categories (three digits required; five digits optional) for those conditions requiring changed medical or treatment regimen (no surgical or V-codes):

| Changed Medical Regimen Diagnosis | ICD-9-CM |
|---|---|
| a. _____ | (__ __ __ . __ __) |
| b. _____ | (__ __ __ . __ __) |
| c. _____ | (__ __ __ . __ __) |
| d. _____ | (__ __ __ . __ __) |

10. **(M0220) Conditions Prior to Medical or Treatment Regimen Change or Inpatient Stay Within Past 14 Days:** If this patient experienced an inpatient facility discharge or change in medical or treatment regimen within the past 14 days, indicate any conditions which existed prior to the inpatient stay or change in medical or treatment regimen. **(Mark all that apply.)**
    - ☐ 1 - Urinary incontinence
    - ☐ 2 - Indwelling/suprapubic catheter
    - ☐ 3 - Intractable pain
    - ☐ 4 - Impaired decision-making
    - ☐ 5 - Disruptive or socially inappropriate behavior
    - ☐ 6 - Memory loss to the extent that supervision required
    - ☐ 7 - None of the above
    - ☐ NA - No inpatient facility discharge and no change in medical or treatment regimen in past 14 days
    - ☐ UK - Unknown

## B. CURRENT ILLNESS

1. **(M0230/M0240) Diagnoses and Severity Index:** List each medical diagnosis or problem for which the patient is receiving home care and ICD-9-CM code category (three digits required; five digits optional - no surgical or V-codes) and rate them using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) ICD-9-CM sequencing requirements must be followed if multiple coding is used for any diagnoses.

   0 - Asymptomatic, no treatment needed at this time
   1 - Symptoms well controlled with current therapy
   2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
   3 - Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring
   4 - Symptoms poorly controlled, history of rehospitalizations

| (M0230) Primary Diagnosis | ICD-9-CM | Severity Rating |
|---|---|---|
| a. _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| **(M0240) Other Diagnoses** | **ICD-9-CM** | **Severity Rating** |
| b. _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| c. _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| d. _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| e. _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| f. _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |

2. **Patient/Family Knowledge and Coping Level Regarding Present Illness**:

   Patient:

   Family:

## C. SIGNIFICANT PAST HEALTH HISTORY:

## D. (M0250) THERAPIES the patient receives at home: (Mark all that apply.)

☐ 1 - Intravenous or infusion therapy (excludes TPN)
☐ 2 - Parenteral nutrition (TPN or lipids)
☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
☐ 4 - None of the above

## E. PROGNOSIS

1. **(M0260) Overall Prognosis:** BEST description of patient's overall prognosis for recovery from this episode of illness.
   ☐ 0 - Poor: little or no recovery is expected and/or further decline is imminent
   ☐ 1 - Good/Fair: partial to full recovery is expected
   ☐ UK - Unknown

2. **(M0270) Rehabilitative Prognosis:** BEST description of patient's prognosis for functional status.
   ☐ 0 - Guarded: minimal improvement in functional status is expected; decline is possible
   ☐ 1 - Good: marked improvement in functional status is expected
   ☐ UK - Unknown

3. **(M0280) Life Expectancy:** (Physician documentation is not required.)
   ☐ 0 - Life expectancy is greater than 6 months
   ☐ 1 - Life expectancy is 6 months or fewer

## F. ALLERGIES: (Environmental, drugs, food, etc.)

## G. IMMUNIZATION/SCREENING TESTS

1. **Immunizations:** Flu Yes ___ No ___ Date _____ Pneumonia Yes ___ No ___ Date _____
   Tetanus Yes ___ No ___ Date _____ Other:_____ Date _____
2. **Screening:** Cholesterol level Yes ___ No ___ Date _____ Colon cancer screen Yes ___ No ___ Date _____
   Mammogram Yes ___ No ___ Date _____ Prostate cancer screen Yes ___ No ___ Date _____
3. **Self-Exam Frequency:** Breast self-exam frequency _____ Testicular self-exam frequency _____

## H. (M0290) HIGH RISK FACTORS characterizing this patient: **(Mark all that apply.)**

- ☐ 1 - Heavy smoking
- ☐ 2 - Obesity
- ☐ 3 - Alcohol dependency
- ☐ 4 - Drug dependency
- ☐ 5 - None of the above
- ☐ UK - Unknown

## I. LIVING ARRANGEMENTS

1. **(M0300) Current Residence**:
   - ☐ 1 - Patient's owned or rented residence (house, apartment, or mobile home owned or rented by patient/couple/significant other)
   - ☐ 2 - Family member's residence
   - ☐ 3 - Boarding home or rented room
   - ☐ 4 - Board and care or assisted living facility
   - ☐ 5 - Other (specify) _____
2. **(M0340) Patient Lives With: (Mark all that apply.)**
   - ☐ 1 - Lives alone
   - ☐ 2 - With spouse or significant other
   - ☐ 3 - With other family member
   - ☐ 4 - With a friend
   - ☐ 5 - With paid help (other than home care agency staff)
   - ☐ 6 - With other than above

**COMMENTS:**

3. **Physical Environment** (Check to indicate presence of problem or check, "No problems identified."
   - ☐ 1 - No problems identified
   - ☐ 2 - High crime area
   - ☐ 3 - Electrical hazards
   - ☐ 4 - Structural hazards
   - ☐ 5 - Stairs
   - ☐ 6 - Water supply problems
   - ☐ 7 - Sewage disposal problems
   - ☐ 8 - Insect/rodent problems
   - ☐ 9 - Food storage or preparation problems
   - ☐ 10 - Telephone access problem
   - ☐ 11 - Other

## J. OTHERS LIVING IN HOUSEHOLD:

| Name | Age | Sex | Relationship | Able & willing to assist? | Name | Age | Sex | Relationship | Able & willing to assist? |
|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

## K. SUPPORTIVE ASSISTANCE

1. **Names of Persons/Organizations Providing Assistance:**

2. **(M0350) Assisting Person(s) Other than Home Care Agency Staff: (Mark all that apply.)**
   - ☐ 1 - Relatives, friends, or neighbors living outside the home
   - ☐ 2 - Person residing in the home (EXCLUDING paid help)
   - ☐ 3 - Paid help
   - ☐ 4 - None of the above **[ If None of the above, go to *Section L - Review of Systems/Physical Assessment* ]**
   - ☐ UK - Unknown **[ If Unknown, go to *Section L - Review of Systems/Physical Assessment* ]**

3. **(M0360) Primary Caregiver** taking lead responsibility for providing or managing the patient's care, providing the most frequent assistance, etc. (other than home care agency staff):
   - ☐ 0 - No one person **[ If No one person, go to *Section L - Review of Systems/Physical Assessment* ]**
   - ☐ 1 - Spouse or significant other
   - ☐ 2 - Daughter or son
   - ☐ 3 - Other family member
   - ☐ 4 - Friend or neighbor or community or church member
   - ☐ 5 - Paid help
   - ☐ UK - Unknown **[ If Unknown, go to *Section L - Review of Systems/Physical Assessment* ]**

4. **(M0370) How Often** does the patient receive assistance from the primary caregiver?
   - ☐ 1 - Several times during day and night
   - ☐ 2 - Several times during day
   - ☐ 3 - Once daily
   - ☐ 4 - Three or more times per week
   - ☐ 5 - One to two times per week
   - ☐ 6 - Less often than weekly
   - ☐ UK - Unknown

5. **(M0380) Type of Primary Caregiver Assistance: (Mark all that apply.)**
   - ☐ 1 - ADL assistance (e.g., bathing, dressing, toileting, bowel/bladder, eating/feeding)
   - ☐ 2 - IADL assistance (e.g., meds, meals, housekeeping, laundry, telephone, shopping, finances)
   - ☐ 3 - Environmental support (housing, home maintenance)
   - ☐ 4 - Psychosocial support (socialization, companionship, recreation)
   - ☐ 5 - Advocates or facilitates patient's participation in appropriate medical care
   - ☐ 6 - Financial agent, power of attorney, or conservator of finance
   - ☐ 7 - Health care agent, conservator of person, or medical power of attorney
   - ☐ UK - Unknown

**Comments regarding assistance available to patient:**

## L. REVIEW OF SYSTEMS/PHYSICAL ASSESSMENT

(Mark S for subjective, O for objectively assessed problem. If no problem present or if not assessed, mark NA.)

1. **HEAD:** ____ Dizziness ____ Headache (describe location, duration) _____

2. **EYES:** ____ Glasses ____ Blurred/double vision ____ Glaucoma ____ Cataracts ____ PERRL ____ Other (specify) _____

   **(M0390) Vision** with corrective lenses if the patient usually wears them:
   - ☐ 0 - Normal vision: sees adequately in most situations; can see medication labels, newsprint.
   - ☐ 1 - Partially impaired: cannot see medication labels or newsprint, but can see obstacles in path, and the surrounding layout; can count fingers at arm's length.
   - ☐ 2 - Severely impaired: cannot locate objects without hearing or touching them or patient nonresponsive.

3. **EARS:** ____ Hearing Aid ____ Tinnitus ____ Other (specify) _____

   **(M0400) Hearing and Ability to Understand Spoken Language** in patient's own language (with hearing aids if the patient usually uses them):
   - ☐ 0 - No observable impairment. Able to hear and understand complex or detailed instructions and extended or abstract conversation.
   - ☐ 1 - With minimal difficulty, able to hear and understand most multi-step instructions and ordinary conversation. May need occasional repetition, extra time, or louder voice.
   - ☐ 2 - Has moderate difficulty hearing and understanding simple, one-step instructions and brief conversation; needs frequent prompting or assistance.
   - ☐ 3 - Has severe difficulty hearing and understanding simple greetings and short comments. Requires multiple repetitions, restatements, demonstrations, additional time.
   - ☐ 4 - Unable to hear and understand familiar words or common expressions consistently, or patient nonresponsive.

Client's Name:

Client Record No.

4. **ORAL:** ____ Gum problems ____ Chewing problems ____ Dentures ____ Other (specify) _____

**(M0410) Speech and Oral (Verbal) Expression of Language** (in patient's own language):
- ☐ 0 - Expresses complex ideas, feelings, and needs clearly, completely, and easily in all situations with no observable impairment.
- ☐ 1 - Minimal difficulty in expressing ideas and needs (may take extra time; makes occasional errors in word choice, grammar or speech intelligibility; needs minimal prompting or assistance).
- ☐ 2 - Expresses simple ideas or needs with moderate difficulty (needs prompting or assistance, errors in word choice, organization or speech intelligibility). Speaks in phrases or short sentences.
- ☐ 3 - Has severe difficulty expressing basic ideas or needs and requires maximal assistance or guessing by listener. Speech limited to single words or short phrases.
- ☐ 4 - Unable to express basic needs even with maximal prompting or assistance but is not comatose or unresponsive (e.g., speech is nonsensical or unintelligible).
- ☐ 5 - Patient nonresponsive or unable to speak.

5. **NOSE AND SINUS:** ____ Epistaxis ____ Other (specify) _____

6. **NECK AND THROAT:** ____ Hoarseness ____ Difficulty swallowing ____ Other (specify) _____

7. **MUSCULOSKELETAL, NEUROLOGICAL:**

| | | | |
|---|---|---|---|
| ____ Hx arthritis | ____ Joint pain | ____ Syncope | ____ Paralysis (describe) _____ |
| ____ Gout | ____ Weakness | ____ Seizure | ____ Amputation (where) _____ |
| ____ Stiffness | ____ Leg cramps | ____ Tenderness | ____ Tremor |
| ____ Swollen joints | ____ Numbness | ____ Deformities | ____ Aphasia/inarticulate speech |
| ____ Unequal grasp | ____ Temp changes | ____ Comatose | ____ Other (specify) _____ |

Coordination, gait, balance (describe):

**COMMENTS:** (Prostheses, appliances)

**Patient's Perceived Pain Level:** _____ (Scale 0-10)

**(M0420) Frequency of Pain** interfering with patient's activity or movement:
- ☐ 0 - Patient has no pain or pain does not interfere with activity or movement
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time

**(M0430) Intractable Pain**: Is the patient experiencing pain that is not easily relieved, occurs at least daily, and affects the patient's sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, or ability or desire to perform physical activity?
- ☐ 0 - No
- ☐ 1 - Yes

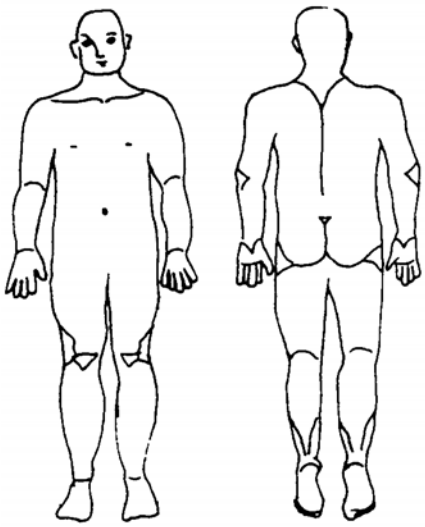
**Comments on pain management:**

Client's Name:
Client Record No.

8. **INTEGUMENT:**

a. ____ Hair changes (where) _____ ____ Pruritus ____ Other (specify) _____

b. Skin condition (Record type # on body area. Indicate size to right of numbered category.)



| | Type | Size |
|---|---|---|
| 1. | Lesions | |
| 2. | Bruises | |
| 3. | Masses | |
| 4. | Scars | |
| 5. | Stasis Ulcers | |
| 6. | Pressure Ulcers | |
| 7. | Surgical Wounds | |
| 8. | Other (specify) _____ | |

c. **(M0440)** Does this patient have a **Skin Lesion** or an **Open Wound**? This excludes "OSTOMIES."
☐ 0 - No **[ If No, go to *Section 9 - Cardiorespiratory* ]**
☐ 1 - Yes

d. **(M0445)** Does this patient have a **Pressure Ulcer**?
☐ 0 - No **[ If No, go to *#8.e - Stasis Ulcer* ]**
☐ 1 - Yes

**(M0450) Current Number of Pressure Ulcers at Each Stage:** (Circle one response for each stage.)

| Pressure Ulcer Stages | Number of Pressure Ulcers | | | | |
|---|---|---|---|---|---|
| a) Stage 1: Nonblanchable erythema of intact skin; the heralding of skin ulceration. In darker-pigmented skin, warmth, edema, hardness, or discolored skin may be indicators. | 0 | 1 | 2 | 3 | 4 or more |
| b) Stage 2: Partial thickness skin loss involving epidermis and/or dermis. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater. | 0 | 1 | 2 | 3 | 4 or more |
| c) Stage 3: Full-thickness skin loss involving damage or necrosis of subcutaneous tissue which may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue. | 0 | 1 | 2 | 3 | 4 or more |
| d) Stage 4: Full-thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone, or supporting structures (e.g., tendon, joint capsule, etc.). | 0 | 1 | 2 | 3 | 4 or more |
| e) In addition to the above, is there at least one pressure ulcer that cannot be observed due to the presence of eschar or a nonremovable dressing, including casts? ☐ 0 - No ☐ 1 - Yes | | | | | |

**(M0460) Stage of Most Problematic (Observable) Pressure Ulcer:**
☐ 1 - Stage 1
☐ 2 - Stage 2
☐ 3 - Stage 3
☐ 4 - Stage 4
☐ NA - No observable pressure ulcer

**(M0464) Status of Most Problematic (Observable) Pressure Ulcer:**
☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing
☐ NA - No observable pressure ulcer

Describe current treatment approach(es) for pressure ulcer(s):

e. **(M0468)** Does this patient have a **Stasis Ulcer**?
☐ 0 - No **[ If No, go to *#8.f - Surgical Wound* ]**
☐ 1 - Yes

**(M0470) Current Number of Observable Stasis Ulcer(s):**
☐ 0 - Zero
☐ 1 - One
☐ 2 - Two
☐ 3 - Three
☐ 4 - Four or more

**(M0474)** Does this patient have at least one **Stasis Ulcer that Cannot be Observed** due to the presence of a nonremovable dressing?
☐ 0 - No
☐ 1 - Yes

**(M0476) Status of Most Problematic (Observable) Stasis Ulcer:**
☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing
☐ NA - No observable stasis ulcer

Describe current treatment approach(es) for stasis ulcer(s):

f. **(M0482)** Does this patient have a **Surgical Wound**?
☐ 0 - No **[ If No, go to *Section 9 - Cardiorespiratory* ]**
☐ 1 - Yes

**(M0484) Current Number of (Observable) Surgical Wounds:** (If a wound is partially closed but has more than one opening, consider each opening as a separate wound.)
☐ 0 - Zero
☐ 1 - One
☐ 2 - Two
☐ 3 - Three
☐ 4 - Four or more

**(M0486)** Does this patient have at least one **Surgical Wound that Cannot be Observed** due to the presence of a nonremovable dressing?
☐ 0 - No
☐ 1 - Yes

**(M0488) Status of Most Problematic (Observable) Surgical Wound:**
☐ 1 - Fully granulating
☐ 2 - Early/partial granulation
☐ 3 - Not healing
☐ NA - No observable surgical wound

Describe current treatment approach(es) for surgical wound(s):

Other Wounds Requiring Treatment

Type of Wound:

Status:

Current treatment Approach(es):

9. **CARDIORESPIRATORY:** Temperature _____ Respirations _____

**BLOOD PRESSURE:** Lying _____ Sitting _____ Standing _____

**PULSE:** Apical rate _____ Radial rate _____ Rhythm _____ Quality _____

**CARDIOVASCULAR:**

____Palpitations ____Dyspnea on exertion ____BP problems ____Murmurs

____Claudication ____Paroxysmal nocturnal dyspnea ____Chest pain ____Edema

____Fatigues easily ____Orthopnea (# of pillows _____) ____Cardiac problems (specify) _____ ____Cyanosis

____Pacemaker _____ ____Other (specify) _____ ____Varicosities
(Date of last battery change)

**COMMENTS:**

**RESPIRATORY:**

History of: _____ Asthma _____ Bronchitis _____ Pneumonia _____ Other (specify) _____
_____ TB _____ Pleurisy _____ Emphysema

**Present Condition:**

_____ Cough (describe) _____ _____ Sputum (character and amount) _____

_____ Breath sounds (describe) _____ _____ Other (specify) _____

**(M0490)** When is the patient dyspneic or noticeably **Short of Breath**?
☐ 0 - Never, patient is not short of breath
☐ 1 - When walking more than 20 feet, climbing stairs
☐ 2 - With moderate exertion (e.g., while dressing, using commode or bedpan, walking distances less than 20 feet)
☐ 3 - With minimal exertion (e.g., while eating, talking, or performing other ADLs) or with agitation
☐ 4 - At rest (during day or night)

**(M0500) Respiratory Treatments** utilized at home: **(Mark all that apply.)**
☐ 1 - Oxygen (intermittent or continuous)
☐ 2 - Ventilator (continually or at night)
☐ 3 - Continuous positive airway pressure
☐ 4 - None of the above

**COMMENTS:**

10. **GENITOURINARY TRACT:**

____ Frequency ____ Nocturia ____ Dysmenorrhea ____ Gravida/Para
____ Pain ____ Urgency ____ Lesions ____ Date last PAP test
____ Hematuria ____ Prostate disorder ____ Hx hysterectomy ____ Contraception
____ Vaginal discharge/bleeding ____ Other (specify)_____

**(M0510)** Has this patient been treated for a **Urinary Tract Infection** in the past 14 days?
☐ 0 - No
☐ 1 - Yes
☐ NA - Patient on prophylactic treatment
☐ UK - Unknown

**(M0520) Urinary Incontinence or Urinary Catheter Presence:**
☐ 0 - No incontinence or catheter (includes anuria or ostomy for urinary drainage) **[ If No, go to *Section 11 - Gastrointestinal Tract* ]**
☐ 1 - Patient is incontinent
☐ 2 - Patient requires a urinary catheter (i.e., external, indwelling, intermittent, suprapubic) **[ Go to *Section 11 - Gastrointestinal Tract* ]**

**(M0530) When** does **Urinary Incontinence** occur?
☐ 0 - Timed-voiding defers incontinence
☐ 1 - During the night only
☐ 2 - During the day and night

**COMMENTS:** (e.g., appliances and care, bladder programs, catheter type and care)

11. **GASTROINTESTINAL TRACT:**

____ Indigestion ____ Pain ____ Rectal bleeding ____ Jaundice
____ Nausea, vomiting ____ Hernias (where) _____ ____ Hemorrhoids ____ Tenderness
____ Ulcers ____ Diarrhea/constipation ____ Gallbladder problems ____ Other (specify) _____

**(M0540) Bowel Incontinence Frequency:**
☐ 0 - Very rarely or never has bowel incontinence
☐ 1 - Less than once weekly
☐ 2 - One to three times weekly
☐ 3 - Four to six times weekly
☐ 4 - On a daily basis
☐ 5 - More often than once daily
☐ NA - Patient has ostomy for bowel elimination
☐ UK - Unknown

**(M0550) Ostomy for Bowel Elimination:** Does this patient have an ostomy for bowel elimination that (within the last 14 days): a) was related to an inpatient facility stay, or b) necessitated a change in medical or treatment regimen?
☐ 0 - Patient does not have an ostomy for bowel elimination.
☐ 1 - Patient's ostomy was not related to an inpatient stay and did not necessitate change in medical or treatment regimen.
☐ 2 - The ostomy was related to an inpatient stay or did necessitate change in medical or treatment regimen.

**COMMENTS:** (bowel function, use of laxatives or enemas, bowel program, GI status)

Client's Name:

Client Record No.

12. **NUTRITIONAL STATUS:**

____ Weight loss/gain last 3 mos. (Give amount _____) ____ Over/under weight ____ Change in appetite Diet _____

____ Other (specify) _____ Meals prepared by _____

**COMMENTS:**

13. **BREASTS:** (For both male and female)

____ Lumps ____ Tenderness _____ Discharge _____ Pain ____ Other (specify) _____

**COMMENTS:**

14. **NEURO/EMOTIONAL/BEHAVIORAL STATUS:**

____ Hx of previous psych. illness ____ Other (specify) _____

**(M0560) Cognitive Functioning:** (Patient's current level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.)

- ☐ 0 - Alert/oriented, able to focus and shift attention, comprehends and recalls task directions independently.
- ☐ 1 - Requires prompting (cueing, repetition, reminders) only under stressful or unfamiliar conditions.
- ☐ 2 - Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low stimulus environment due to distractibility.
- ☐ 3 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- ☐ 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

**(M0570) When Confused (Reported or Observed):**

- ☐ 0 - Never
- ☐ 1 - In new or complex situations only
- ☐ 2 - On awakening or at night only
- ☐ 3 - During the day and evening, but not constantly
- ☐ 4 - Constantly
- ☐ NA - Patient nonresponsive

**(M0580) When Anxious (Reported or Observed):**

- ☐ 0 - None of the time
- ☐ 1 - Less often than daily
- ☐ 2 - Daily, but not constantly
- ☐ 3 - All of the time
- ☐ NA - Patient nonresponsive

**(M0590) Depressive Feelings Reported or Observed in Patient: (Mark all that apply.)**

- ☐ 1 - Depressed mood (e.g., feeling sad, tearful)
- ☐ 2 - Sense of failure or self reproach
- ☐ 3 - Hopelessness
- ☐ 4 - Recurrent thoughts of death
- ☐ 5 - Thoughts of suicide
- ☐ 6 - None of the above feelings observed or reported

**(M0610) Behaviors Demonstrated at Least Once a Week (Reported or Observed): (Mark all that apply.)**

- ☐ 1 - Memory deficit: failure to recognize familiar persons/places, inability to recall events of past 24 hours, significant memory loss so that supervision is required
- ☐ 2 - Impaired decision-making: failure to perform usual ADLs or IADLs, inability to appropriately stop activities, jeopardizes safety through actions
- ☐ 3 - Verbal disruption: yelling, threatening, excessive profanity, sexual references, etc.
- ☐ 4 - Physical aggression: aggressive or combative to self and others (e.g., hits self, throws objects, punches, dangerous maneuvers with wheelchair or other objects)
- ☐ 5 - Disruptive, infantile, or socially inappropriate behavior (**excludes** verbal actions)
- ☐ 6 - Delusional, hallucinatory, or paranoid behavior
- ☐ 7 - None of the above behaviors demonstrated

**(M0620) Frequency of Behavior Problems (Reported or Observed)** (e.g., wandering episodes, self abuse, verbal disruption, physical aggression, etc.):

- ☐ 0 - Never
- ☐ 1 - Less than once a month
- ☐ 2 - Once a month
- ☐ 3 - Several times each month
- ☐ 4 - Several times a week
- ☐ 5 - At least daily

**(M0630)** Is this patient receiving **Psychiatric Nursing Services** at home provided by a qualified psychiatric nurse?

- ☐ 0 - No
- ☐ 1 - Yes

**COMMENTS:** (describe other related behaviors or symptoms, e.g., weight loss, sleep disturbances, coping skills)

15. **ENDOCRINE AND HEMATOPOIETIC:**

____ Diabetes ____ Polyuria ____ Polydipsia ____ Thyroid problem ____ Excessive bleeding or bruising

Fractionals: Usual results _____ ____ Intolerance to heat and cold

Frequency checked _____ ____ Other (specify) _____

**COMMENTS:**

**M. LIFE SYSTEM PROFILE: For M0640-M0800, complete the "Current" column for all patients. For these same items, complete the "Prior" column only at start of care and at resumption of care; mark the level that corresponds to the patient's condition 14 days prior to start of care date (M0030) or resumption of care date (M0032). In all cases, record what the patient is *able to do*.**

1. **(M0640) Grooming:** Ability to tend to personal hygiene needs (i.e., washing face and hands, hair care, shaving or make up, teeth or denture care, fingernail care).

Prior Current
- ☐ ☐ 0 - Able to groom self unaided, with or without the use of assistive devices or adapted methods.
- ☐ ☐ 1 - Grooming utensils must be placed within reach before able to complete grooming activities.
- ☐ ☐ 2 - Someone must assist the patient to groom self.
- ☐ ☐ 3 - Patient depends entirely upon someone else for grooming needs.
- ☐ UK - Unknown

2. **(M0650) Ability to Dress Upper Body** (with or without dressing aids) including undergarments, pullovers, front-opening shirts and blouses, managing zippers, buttons, and snaps:

Prior Current
- ☐ ☐ 0 - Able to get clothes out of closets and drawers, put them on and remove them from the upper body without assistance.
- ☐ ☐ 1 - Able to dress upper body without assistance if clothing is laid out or handed to the patient.
- ☐ ☐ 2 - Someone must help the patient put on upper body clothing.
- ☐ ☐ 3 - Patient depends entirely upon another person to dress the upper body.
- ☐ UK - Unknown

3. **(M0660) Ability to Dress Lower Body** (with or without dressing aids) including undergarments, slacks, socks or nylons, shoes:

Prior Current
- ☐ ☐ 0 - Able to obtain, put on, and remove clothing and shoes without assistance.
- ☐ ☐ 1 - Able to dress lower body without assistance if clothing and shoes are laid out or handed to the patient.
- ☐ ☐ 2 - Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- ☐ ☐ 3 - Patient depends entirely upon another person to dress lower body.
- ☐ UK - Unknown

4. **(M0670) Bathing:** Ability to wash entire body. **Excludes grooming (washing face and hands only).**

Prior Current
- ☐ ☐ 0 - Able to bathe self in shower or tub independently.
- ☐ ☐ 1 - With the use of devices, is able to bathe self in shower or tub independently.
- ☐ ☐ 2 - Able to bathe in shower or tub with the assistance of another person:
  (a) for intermittent supervision or encouragement or reminders, OR
  (b) to get in and out of the shower or tub, OR
  (c) for washing difficult to reach areas.
- ☐ ☐ 3 - Participates in bathing self in shower or tub, but requires presence of another person throughout the bath for assistance or supervision.
- ☐ ☐ 4 - Unable to use the shower or tub and is bathed in bed or bedside chair.
- ☐ ☐ 5 - Unable to effectively participate in bathing and is totally bathed by another person.
- ☐ UK - Unknown

5. **(M0680) Toileting:** Ability to get to and from the toilet or bedside commode.

Prior Current
- ☐ ☐ 0 - Able to get to and from the toilet independently with or without a device.
- ☐ ☐ 1 - When reminded, assisted, or supervised by another person, able to get to and from the toilet.
- ☐ ☐ 2 - Unable to get to and from the toilet but is able to use a bedside commode (with or without assistance).
- ☐ ☐ 3 - Unable to get to and from the toilet or bedside commode but is able to use a bedpan/urinal independently.
- ☐ ☐ 4 - Is totally dependent in toileting.
- ☐ UK - Unknown

6. **(M0690) Transferring:** Ability to move from bed to chair, on and off toilet or commode, into and out of tub or shower, and ability to turn and position self in bed if patient is bedfast.

Prior Current
- ☐ ☐ 0 - Able to independently transfer.
- ☐ ☐ 1 - Transfers with minimal human assistance or with use of an assistive device.
- ☐ ☐ 2 - Unable to transfer self but is able to bear weight and pivot during the transfer process.
- ☐ ☐ 3 - Unable to transfer self and is unable to bear weight or pivot when transferred by another person.
- ☐ ☐ 4 - Bedfast, unable to transfer but is able to turn and position self in bed.
- ☐ ☐ 5 - Bedfast, unable to transfer and is unable to turn and position self.
- ☐ UK - Unknown

7. **(M0700) Ambulation/Locomotion:** Ability to SAFELY walk, once in a standing position, or use a wheelchair, once in a seated position, on a variety of surfaces.

Prior Current
- ☐ ☐ 0 - Able to independently walk on even and uneven surfaces and climb stairs with or without railings (i.e., needs no human assistance or assistive device).
- ☐ ☐ 1 - Requires use of a device (e.g., cane, walker) to walk alone or requires human supervision or assistance to negotiate stairs or steps or uneven surfaces.
- ☐ ☐ 2 - Able to walk only with the supervision or assistance of another person at all times.
- ☐ ☐ 3 - Chairfast, unable to ambulate but is able to wheel self independently.
- ☐ ☐ 4 - Chairfast, unable to ambulate and is unable to wheel self.
- ☐ ☐ 5 - Bedfast, unable to ambulate or be up in a chair.
- ☐ UK - Unknown

8. **(M0710) Feeding or Eating:** Ability to feed self meals and snacks. **Note: This refers only to the process of eating, chewing, and swallowing, not preparing the food to be eaten.**

Prior Current
- ☐ ☐ 0 - Able to independently feed self.
- ☐ ☐ 1 - Able to feed self independently but requires:
  (a) meal set-up; OR
  (b) intermittent assistance or supervision from another person; OR
  (c) a liquid, pureed or ground meat diet.
- ☐ ☐ 2 - Unable to feed self and must be assisted or supervised throughout the meal/snack.
- ☐ ☐ 3 - Able to take in nutrients orally and receives supplemental nutrients through a nasogastric tube or gastrostomy.
- ☐ ☐ 4 - Unable to take in nutrients orally and is fed nutrients through a nasogastric tube or gastrostomy.
- ☐ ☐ 5 - Unable to take in nutrients orally or by tube feeding.
- ☐ UK - Unknown

9. **(M0720) Planning and Preparing Light Meals** (e.g., cereal, sandwich) or reheat delivered meals:

Prior Current
- ☐ ☐ 0 - (a) Able to independently plan and prepare all light meals for self or reheat delivered meals; OR
  (b) Is physically, cognitively, and mentally able to prepare light meals on a regular basis but has not routinely performed light meal preparation in the past (i.e., prior to this home care admission).
- ☐ ☐ 1 - Unable to prepare light meals on a regular basis due to physical, cognitive, or mental limitations.
- ☐ ☐ 2 - Unable to prepare any light meals or reheat any delivered meals.
- ☐ UK - Unknown

10. **(M0730) Transportation:** Physical and mental ability to safely use a car, taxi, or public transportation (bus, train, subway).

Prior Current
- ☐ ☐ 0 - Able to independently drive a regular or adapted car; OR uses a regular or handicap-accessible public bus.
- ☐ ☐ 1 - Able to ride in a car only when driven by another person; OR able to use a bus or handicap van only when assisted or accompanied by another person.
- ☐ ☐ 2 - Unable to ride in a car, taxi, bus, or van, and requires transportation by ambulance.
- ☐ UK - Unknown

11. **(M0740) Laundry:** Ability to do own laundry -- to carry laundry to and from washing machine, to use washer and dryer, to wash small items by hand.

Prior Current
- ☐ ☐ 0 - (a) Able to independently take care of all laundry tasks; OR
  (b) Physically, cognitively, and mentally able to do laundry and access facilities, but has not routinely performed laundry tasks in the past (i.e., prior to this home care admission).
- ☐ ☐ 1 - Able to do only light laundry, such as minor hand wash or light washer loads. Due to physical, cognitive, or mental limitations, needs assistance with heavy laundry such as carrying large loads of laundry.
- ☐ ☐ 2 - Unable to do any laundry due to physical limitation or needs continual supervision and assistance due to cognitive or mental limitation.
- ☐ UK - Unknown

12. **(M0750) Housekeeping:** Ability to safely and effectively perform light housekeeping and heavier cleaning tasks.

Prior Current
- ☐ ☐ 0 - (a) Able to independently perform all housekeeping tasks; OR
  (b) Physically, cognitively, and mentally able to perform all housekeeping tasks but has not routinely participated in housekeeping tasks in the past (i.e., prior to this home care admission).
- ☐ ☐ 1 - Able to perform only light housekeeping (e.g., dusting, wiping kitchen counters) tasks independently.
- ☐ ☐ 2 - Able to perform housekeeping tasks with intermittent assistance or supervision from another person.
- ☐ ☐ 3 - Unable to consistently perform any housekeeping tasks unless assisted by another person throughout the process.
- ☐ ☐ 4 - Unable to effectively participate in any housekeeping tasks.
- ☐ UK - Unknown

13. **(M0760) Shopping:** Ability to plan for, select, and purchase items in a store and to carry them home or arrange delivery.

Prior Current
- ☐ ☐ 0 - (a) Able to plan for shopping needs and independently perform shopping tasks, including carrying packages; OR
  (b) Physically, cognitively, and mentally able to take care of shopping, but has not done shopping in the past (i.e., prior to this home care admission).
- ☐ ☐ 1 - Able to go shopping, but needs some assistance:
  (a) By self is able to do only light shopping and carry small packages, but needs someone to do occasional major shopping; OR
  (b) Unable to go shopping alone, but can go with someone to assist.
- ☐ ☐ 2 - Unable to go shopping, but is able to identify items needed, place orders, and arrange home delivery.
- ☐ ☐ 3 - Needs someone to do all shopping and errands.
- ☐ UK - Unknown

14. **(M0770) Ability to Use Telephone:** Ability to answer the phone, dial numbers, and effectively use the telephone to communicate.

Prior Current
- ☐ ☐ 0 - Able to dial numbers and answer calls appropriately and as desired.
- ☐ ☐ 1 - Able to use a specially adapted telephone (i.e., large numbers on the dial, teletype phone for the deaf) and call essential numbers.
- ☐ ☐ 2 - Able to answer the telephone and carry on a normal conversation but has difficulty with placing calls.
- ☐ ☐ 3 - Able to answer the telephone only some of the time or is able to carry on only a limited conversation.
- ☐ ☐ 4 - Unable to answer the telephone at all but can listen if assisted with equipment.
- ☐ ☐ 5 - Totally unable to use the telephone.
- ☐ ☐ NA - Patient does not have a telephone.
- ☐ UK - Unknown

15. **(M0780) Management of Oral Medications:** Patient's ability to prepare and take all prescribed oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

Prior Current
- ☐ ☐ 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- ☐ ☐ 1 - Able to take medication(s) at the correct times if:
  (a) individual dosages are prepared in advance by another person; OR
  (b) given daily reminders; OR
  (c) someone develops a drug diary or chart.
- ☐ ☐ 2 - Unable to take medication unless administered by someone else.
- ☐ ☐ NA - No oral medications prescribed.
- ☐ UK - Unknown

16. **(M0790) Management of Inhalant/Mist Medications:** Patient's ability to prepare and take all prescribed inhalant/mist medications (nebulizers, metered dose devices) reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes all other forms of medication (oral tablets, injectable and IV medications).**

Prior Current
- ☐ ☐ 0 - Able to independently take the correct medication and proper dosage at the correct times.
- ☐ ☐ 1 - Able to take medication at the correct times if:
  (a) individual dosages are prepared in advance by another person, OR
  (b) given daily reminders.
- ☐ ☐ 2 - Unable to take medication unless administered by someone else.
- ☐ ☐ NA - No inhalant/mist medications prescribed.
- ☐ UK - Unknown

17. **(M0800) Management of Injectable Medications:** Patient's ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

Prior Current
- ☐ ☐ 0 - Able to independently take the correct medication and proper dosage at the correct times.
- ☐ ☐ 1 - Able to take injectable medication at correct times if:
  (a) individual syringes are prepared in advance by another person, OR
  (b) given daily reminders.
- ☐ ☐ 2 - Unable to take injectable medications unless administered by someone else.
- ☐ ☐ NA - No injectable medications prescribed.
- ☐ UK - Unknown

18. **(M0810) Patient Management of Equipment (includes ONLY oxygen, IV/infusion therapy, enteral/parenteral nutrition equipment or supplies):** Patient's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- ☐ 0 - Patient manages all tasks related to equipment completely independently.
- ☐ 1 - If someone else sets up equipment (i.e., fills portable oxygen tank, provides patient with prepared solutions), patient is able to manage all other aspects of equipment.
- ☐ 2 - Patient requires considerable assistance from another person to manage equipment, but independently completes portions of the task.
- ☐ 3 - Patient is only able to monitor equipment (e.g., liter flow, fluid in bag) and must call someone else to manage the equipment.
- ☐ 4 - Patient is completely dependent on someone else to manage all equipment.
- ☐ NA - No equipment of this type used in care **[ If NA, go to *Section N - Therapy Need* ]**

19. **(M0820) Caregiver Management of Equipment (includes ONLY oxygen, IV/infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies):** Caregiver's ability to set up, monitor and change equipment reliably and safely, add appropriate fluids or medication, clean/store/dispose of equipment or supplies using proper technique. **(NOTE: This refers to ability, not compliance or willingness.)**

- ☐ 0 - Caregiver manages all tasks related to equipment completely independently.
- ☐ 1 - If someone else sets up equipment, caregiver is able to manage all other aspects.
- ☐ 2 - Caregiver requires considerable assistance from another person to manage equipment, but independently completes significant portions of task.
- ☐ 3 - Caregiver is only able to complete small portions of task (e.g., administer nebulizer treatment, clean/store/dispose of equipment or supplies).
- ☐ 4 - Caregiver is completely dependent on someone else to manage all equipment.
- ☐ NA - No caregiver
- ☐ UK - Unknown

## N. THERAPY NEED

1. **(M0825) Therapy Need:** Does the care plan of the Medicare payment period for which this assessment will define a case mix group indicate a need for therapy (physical, occupational, or speech therapy) that meets the threshold for a Medicare high-therapy case mix group?

- ☐ 0 - No
- ☐ 1 - Yes
- ☐ NA - Not applicable

## O. EQUIPMENT AND SUPPLIES:

1. Equipment Needs: (check appropriate box)

| | Has | Needs |
|---|---|---|
| a. Oxygen/Respiratory Equip. | | |
| b. Wheelchair | | |
| c. Hospital Bed | | |
| d. Other (specify) | | |

2. Supplies Needed and Comments Regarding Equipment Needs:

3. Financial Problems/Needs:

## P. SAFETY MEASURES RECOMMENDED TO PROTECT PATIENT FROM INJURY:

## Q. EMERGENCY PLANS:

Client's Name:

Client Record No.

**R. CONCLUSIONS/IMPRESSIONS AND SKILLED INTERVENTIONS PERFORMED THIS VISIT:**

Date of Assessment: _____ Signature of Assessor: _____

# FOLLOW-UP ASSESSMENT



Client's Name:

Client Record No.



## A. DEMOGRAPHIC/GENERAL INFORMATION -- Update Patient Tracking Sheet as needed.

1. **(M0080) Discipline of Person Completing Assessment:**

☐ 1 - RN ☐ 3 - SLP/ST
☐ 2 - PT ☐ 4 - OT

2. **(M0090) Date Assessment Completed:**

__ __ – __ __ – __ __ __ __
m m d d y y y y

3. **(M0100) This Assessment is Currently Being Completed for the Following Reason:**

Start/Resumption of Care
- 1 - Start of care—further visits planned
- 3 - Resumption of care (after inpatient stay)

Follow-Up
- ☐ **4 - Recertification (follow-up) reassessment [ Go to *M0175* ]**
- ☐ **5 - Other follow-up [ Go to *M0175* ]**

Transfer to an Inpatient Facility
- 6 - Transferred to an inpatient facility—patient not discharged from agency
- 7 - Transferred to an inpatient facility—patient discharged from agency

Discharge from Agency — Not to an Inpatient Facility
- 8 - Death at home
- 9 - Discharge from agency

4. **(M0175)** From which of the following **Inpatient Facilities** was the patient discharged during the past 14 days? **(Mark all that apply.)**
- ☐ 1 - Hospital
- ☐ 2 - Rehabilitation facility
- ☐ 3 - Skilled nursing facility
- ☐ 4 - Other nursing home
- ☐ 5 - Other (specify) _____
- ☐ NA - Patient was not discharged from an inpatient facility

5. **(M0230/M0240) Diagnoses and Severity Index:** List each medical diagnosis or problem for which the patient is receiving home care and ICD-9-CM code category (three digits required; five digits optional - no surgical or V-codes) and rate it using the following severity index. (Choose one value that represents the most severe rating appropriate for each diagnosis.) ICD-9-CM sequencing requirements must be followed if multiple coding is used for any diagnoses.

0 - Asymptomatic, no treatment needed at this time
1 - Symptoms well controlled with current therapy
2 - Symptoms controlled with difficulty, affecting daily functioning; patient needs ongoing monitoring
3 - Symptoms poorly controlled, patient needs frequent adjustment in treatment and dose monitoring
4 - Symptoms poorly controlled, history of rehospitalizations

| | (M0230) Primary Diagnosis | ICD-9-CM | Severity Rating |
|---|---|---|---|
| a. | _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| | **(M0240) Other Diagnoses** | **ICD-9-CM** | **Severity Rating** |
| b. | _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| c. | _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| d. | _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| e. | _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |
| f. | _____ | (__ __ __ . __ __) | ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 |

6. **Patient/Family Knowledge and Coping Level Regarding Present Illness**:

Patient:

Family:

## B. (M0250) THERAPIES the patient receives at home: (Mark all that apply.)

- ☐ 1 - Intravenous or infusion therapy (excludes TPN)
- ☐ 2 - Parenteral nutrition (TPN or lipids)
- ☐ 3 - Enteral nutrition (nasogastric, gastrostomy, jejunostomy, or any other artificial entry into the alimentary canal)
- ☐ 4 - None of the above

## C. HIGH RISK FACTORS

Update information on risk factors: ___ No changes ___ Smoking ___ Alcohol dependency ___ Drug dependency ___ Other